

**CENTRAL INDIANA SYSTEM POINT OF ENTRY
REFERRAL FOR EVALUATION AND ASSESSMENT
Phone: 257-2229 Fax: 205-2592**

Today's Date: _____ Evaluation Completion Date: _____ (Eval must be scheduled within 2 SPOE business days of referral for initials; within 10 SPOE business days for annuals. Eval must be completed within 10 SPOE business days after scheduled for initials; 30-45 days prior to annual due date for annuals.)

Referral for: Initial _____ Annual _____ Re-Eval _____ Other: _____

Updated AEPS Scores: _____ Child is aging out (date): _____ Child is discharged (form attached): _____

IFSP Due Date: _____ Annual IFSP Date (if scheduled): _____

Primary Area(s) of Concern/Discipline(s) Requested for Eval:

PT OT ST DT Other: _____

Please complete the evaluation/assessment as indicated above for:

Child: _____ DOB: _____ Child ID #: _____

Parents: _____ Home Phone: _____

Address: _____ Work Phone: _____
(Apt. complex/housing addition/cross streets)

_____ Best time to call: _____

Referral Source: _____

Physician's Name : _____ Phone: _____

Address: _____ Fax: _____

PHS/Scrip Rec'd? _____ Yes _____ No Date PHS Requested: _____

Ongoing Services:

Discipline	Frequency/Intensity	Provider Name	Phone #	Fax #	Cell #

Referral Made By: _____ Service Coordinator

Intake Coordinator